naccrra
americorps care · vista care

Please read carefully and Initial beside each Item

_____ ⇨ I have been determined eligible (Income and otherwise) to receive childcare benefits through AmeriCorps CARE. I understand that my state determines Income eligibility requirements.

_____ ⇨ I understand that AmeriCorps CARE can only pay **up to** my state's local market rate for childcare fees.

_____ ⇨ I am a full-time AmeriCorps member.

_____ ⇨ I understand that I must select a **legal** caregiver, that my state determines who is considered a legal caregiver, and that AmeriCorps CARE cannot reimburse my caregiver unless all state requirements are met.

_____ ⇨ I understand that I must give AmeriCorps CARE a minimum of two (2) weeks notice when changing caregivers by submitting a **change of caregiver form** and a new **caregiver Information and registration form.**

_____ ⇨ I understand that I must notify my program director Immediately If plan to resign from AmeriCorps. Final payments to my caregiver cannot be made until I complete a **termination of child care benefits form** with my program director **and** submit final coupons (must be correct and complete).

_____ ⇨ I understand that I am **not eligible** for childcare through AmeriCorps CARE If I am receiving a childcare subsidy from another source, nor will AmeriCorps CARE cover any co-pay on existing childcare subsidies.

_____ ⇨ I understand that AmeriCorps CARE will not reimburse more than one caregiver for the same period of time, for the same child and will only reimburse a maximum of two caregivers at a time.

_____ ⇨ I understand that my caregiver must meet the minimum age requirement set by my state (18 yrs. Old In most states).

_____ ⇨ I understand that If I use a back-up caregiver, AmeriCorps CARE must reimburse my primary caregiver <u>before</u> reimbursing my back-up caregiver.

_____ ⇨ I understand that AmeriCorps CARE will not reimburse me for childcare and that all reimbursements are made directly to the caregiver.

I have read all of the above and understand Its content. I also understand that non-compliance with any of the above and/or falsification of Information on any AmeriCorps CARE documents will result in termination of my childcare benefits and that In such a case I my be required to re-pay any monies paid on my behalf.

_____   _____   ____/___/___
Member's Name (please print)   Member's Signature   Date

PLEASE DO NOT USE WHITE OUT; IT WILL BE RETURNED & DELAY PROCESSING